STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	03/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALTENHEIM HEALTH & LIVING COMMUNITY LLC	3525 E HANNA AVE INDIANAPOLIS, IN46237

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: March 21, 22, 23, 24 & 25, 2011 Facility number: 000103 Provider number: 155196 AIM number: 100290000 Survey team: Marcy Smith RN TC Rhonda Stout RN Leia Alley (March 21, 22, 23 & 24, 2011) Diane Dierks RN (March 22, 23 & 24, 2011) Patti Allen BSW (March 22, 24 & 25, 2011) Census bed type: SNF/NF: 69 Residential: 56 Total: 125 Census payor type: Medicare: 6 Medicaid: 39 Other: 80 Total: 125 Sample: 15 Residential sample: 7	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 3-29-11 Cathy Emswiller RN			

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F0248 SS=D	Based on observation, record review, and interview the facility failed to ensure specialized activity programs were provided for residents who were room confined or bedfast. This affected 2 out 13 residents reviewed for activities in a sample of 13. (Residents #42 and #21) Findings include: 1. The clinical record for Resident #42 was reviewed on 3/22/2011 at 3:22 p.m. Diagnoses for Resident #42 included, but were not limited to, dementia, paralysis, osteoporosis, stage 4 pressure ulcer, coronary artery disease, chronic kidney disease, and chronic obstructive pulmonary disease. A review of Resident #42's quarterly assessment dated 3/3/2011, stated the resident, "passively participates in various activity programs on the unit; however, she mostly enjoys visiting with her husband who visits at least 3-5 times a week. A review of Resident #42's activity calendar for March 2011 indicated the only activity the resident was involved in was visits with her family. In an interview with the Unit Manager of	F0248	**This plan of correction is to serve as Altenheim Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Altenheim Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** F248-483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES I. Resident #42 & #21 are now receiving appropriate activities of interest including sensory stimulation, and their care plans have been updated. II. The facility has reviewed activity programs for all residents who are room confined or bedfast. Specialized programs have been put into place where appropriate and the care plans have been updated. III. The systemic change will be all residents who are room confined or bedfast will have an	04/24/2011

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	B Wing, on 3/22/2011 at 4:00 p.m., in regards to Resident #42 activities outside of the resident's room, she indicated the only time the resident left her room was during the meal times. In an interview with the person in charge of activities, on 3/24/2011 at 3:21 p.m., she indicated that she had not tried any other activity with the resident. Observations of Resident #42 on 3/22/2011 at 4:10 p.m., 3/23/2011 at 10:10 p.m., 3/24/2011 at 3:00 p.m., and 3/25/2011 at 10:00 a.m., the resident was in bed with no television, no music, or no family, friends or care givers present. 2. The clinical record for Resident #21 was reviewed on 3/22/2011 at 11:47 a.m. Diagnoses for Resident #21 included, but were not limited to, osteoporosis, hypothyroidism, dementia, and left breast cancer. A review of Resident #21's quarterly assessment dated 1/19/2011, stated the resident, "participates in independent activities daily...self direct her leisure choices daily...prefers her own company." A review of Resident #21's activity		interdisciplinary review of their activity plan of care with interested family members during their quarterly review and as needed with changes. Education will be provided to activity staff regarding specialized activity programs for residents who are room confined or bedfast. IV. The Administrator or the designee will review the activity documentation and observe the activity for a random 5 room confined or bedfast residents per unit weekly for 4 weeks, then every other week for 4 weeks, then monthly for a total of 12 month of auditing/observation. Any identified concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Completion date: 4/24/11	

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	calendar for March 2011 indicated passed March 4th the only activity the resident participated in was watching television. March 1, 2, 3, and 4th the calendar indicated the resident participated in active games, cards and games, chair aerobics, exercise, movement therapy, movie and popcorn, and sit and fit. In an interview with the person in charge of activities, on 3/24/2011 at 3:21 p.m., she indicated the resident did what she wanted. When inquired about 1:1, massage therapy, books on CD, or music being offered to the resident she indicated that it had not been tried. Observations of Resident #21 on 3/22/11 at 4:50 p.m., and 3/23/2011 at 8:45 a.m., she was sitting at the table eating. There were 3 other residents sitting with her. She did not say anything to them or to any of the care givers. Observations of Resident #21 on 3/24/11 at 3:25 p.m., and 3/25/2011 at 9:55 a.m., she was in bed with the television on but she seemed to be preoccupied with her blanket. 3.1-33(a)			

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R0273	Based on observation and interview the facility failed to ensure that food was covered and dated, raw hamburger was not thawing over boxed turkey, facial hair was covered, and failed to ensure that black mold was not growing on the walls in the dietary department. This has the potential of affecting 56 of 56 residents who reside at the facility. Findings include: During the tour of the facility's kitchen conducted with the Dietary Manager on 3/21/2011 at 10:00 a.m., the following observations were made: a) In the salad refrigerator, a gallon size zip lock bag containing what appears to be fruit salad, did not have a date on it. b) In the tray line refrigerator, there was 3 bowels of grapes, 5 bowels of apple sauce, and 5 slices of angel food cake, that was not covered or dated. c) The wall to the right of the dishwasher, behind where the dishes are loaded are loaded into the machine, there was black mold growing on the wall. d) The cooler located downstairs, had raw hamburger thawing over a box of turkey.	R0273	**R273-410 IAC 16.2-5-5.1(f) FOOD AND NUTRITIONAL SERVICES – DEFICIENCY I.** **The bag containing fruit salad was discarded upon discovery during the survey.** **The bowls of grapes, apple sauce and angel food cake were discarded upon discovery during the survey** **The mold on the wall to the right of the dishwasher was immediately removed and cleaned during the survey.** **The box of turkey was immediately discarded and the cooler was rearranged appropriately so that no raw meat was thawing above other food items.** **The scoop was removed from the bulk container of sugar and the sugar was discarded.** **Employee #1 and #2 were immediately educated on sanitary conditions and now have any facial hair appropriately covered.** **II.** **All opened food items are now appropriately covered and dated.** **The walls in the dietary department have been cleaned and are free of black mold.** **All foods in the cooler are arranged appropriately so that no raw meat is thawing above other food items.**	04/24/2011

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	e) A scoop was found in the bulk sugar container. f) Employee #1 and Employee #2 had facial hair that is not covered. During an interview with the Dietary Manager, on 3/25/2011 at 9:40 a.m., she indicated the black mold was cleaned off the wall on the evening of 3/21/2011 with bleach..		**Scoops are not left in bulk containers of sugar.** **Employees with facial hair have their hair covered appropriately** **III.** **The systemic change includes a schedule of dietary staff with assignments for daily checklists to include the Dietary Manager to hold staff accountable for the checklist.** **Any newly hired kitchen staff will be trained on the daily checklist during orientation.** **The cleaning schedule has been reviewed and revised to include the items listed above.** **Education was provided for all dietary staff regarding the dating and covering of opened foods, cleaning schedules for the dietary walls, arrangement of foods appropriately in the cooler so that no raw meat is thawing above other food items, scoops are not left in bulk containers, and proper covering of any facial hair.** **IV.** **The Director of Dining Services or designee will complete a daily audit, 5 days a week, of proper storage and dating of opened foods, cleaning of and visual checks of the dietary department for molds, proper covering of facial hair, no scoops left in bulk containers, and appropriate arrangement**	

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			of foods in the cooler so that no raw meat is thawing above other food items. This audit will continue for 30 days, and then will be completed 2 days a week for an additional 60 days, then one day a week for an total of 12 months of monitoring. **Any concerns will be addressed.** **The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **Completion date: 4/24/11**	

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F0279 SS=E	Based on record review and interview the facility failed to ensure care plans were developed based on residents' comprehensive assessments for communication, pain, behaviors, dehydration, oral care and vision for 5 of 13 residents reviewed for having care plans based on their most recent comprehensive assessments in a sample of 15. (Residents #51, #54, #22, #42 and #21) Findings included: 1. The record of Resident #51 was reviewed on 3/22/11 at 4:30 PM. Diagnoses for Resident #51 included, but were not limited to, arterial insufficiency and history of a cerebral vascular accident. (CVA) An annual Minimum Data Set (MDS) dated 2/18/11 indicated Resident #51 had minimal difficulty hearing. The Care Assessment Area (CAA) of Communication indicated "Resident triggered this CAA related to minimal hearing deficit...Has some word finding, thought processing problems related to CVA...Care Plan Decision..Yes...will continue to communicate needs..." A review of the resident's care plans	F0279	F279-483.20(d), 483.20(k)(1) **COMPREHENSIVE CARE PLAN.** **I.** **Resident #51 now has a care plan in place for communication.** **Resident #54 now has a care plan in place for pain.** **Resident #21 now has a care plan in place for vision.** **Resident #42 now has a care plan in place for dehydration.** **Resident #22 now has a care plan in place for behaviors.** **II.** **All residents' most recent comprehensive assessment and triggered care area assessments for communication, pain, behaviors, dehydration, oral care and vision have been reviewed and care plans based on the resident needs and assessment have been developed as needed.** **III.** **The systemic change includes: An interdisciplinary care plan conference will be held within 7 days after the completion of the comprehensive assessment and the conference will include an audit of all care plans relating to the triggered care**	04/24/2011

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	indicated one had not been developed for communication related to her hearing deficit. Further information was requested from the Director of Nursing (DON) on 3/22/11 at 6:02 PM regarding Resident #51 not having a communication care plan. During an interview on 3/23/11 at 10:00 am the DON indicated a communication care plan had not been created for the resident. He provided one dated 3/23/11 addressing the resident's hearing deficit. 2. The record of Resident #54 was reviewed on 3/22/11 at 10:50 am. Diagnoses for Resident #54 included, but were not limited to, history of a fractured left hip, venous stasis ulcers and chronic renal disease. An annual MDS for the resident, dated 1/21/11, indicated she experienced pain "occasionally" and rated her pain at a "5" on a "zero to ten scale." The CAA of Pain indicated "Resident reported during staff interview that she experiences occasional pain, rated 5 on a scale of 1 - 10. Stated pain interferes with day-day activities...Care Plan Decision...Yes...will indicate pain relief..."		**area assessments.** **Education was provided to the MDS Nurses regarding the completion of care plans when triggered by the Care Area Assessment.** **IV.** **The Unit Manager, ADON and/or DON will audit for completion of care plans as triggered by the care area assessment after the completion of a comprehensive assessment. This audit will include 100% of all comprehensive assessments for 3 months, then 2 per unit every month for an additional 9 months.** **Any identified concerns will be addressed.** **The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **Completion date: 4/24/11**	

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	A review of the resident's care plans indicated one had not been developed for pain. Further information was requested from the DON on 3/22/11 at 6:02 PM regarding Resident #54 not having a care plan for pain. On 3/23/11 at 10:00 am the DON indicated a pain care plan had not been developed for the resident. At this time he provided a pain care plan for Resident #54, dated 3/23/11.			

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F0282 SS=D	Based on record review and interview the facility failed to ensure physician's orders and care plans were followed for 1 of 13 residents reviewed for following physician's orders and care plans, in a sample of 13. (Resident #42) Findings include: The clinical record for Resident #42 was reviewed on 3/22/2011 at 3:22 p.m. Diagnoses for Resident #42 included, but were not limited to, dementia, paralysis, osteoporosis, stage 4 pressure ulcer, coronary artery disease, chronic kidney disease, and chronic obstructive pulmonary disease. A recapitulation of physician's order, dated 10/19/2011, indicated Resident #42 was to have a 16 French foley catheter with a 10 milliliter balloon. A care plan for Resident #42, for an indwelling urinary catheter, with a problem and approach date of 9/15/2010, indicated that the resident was to have a 16 French catheter with a 10 milliliter balloon per the MD order. A nurse's noted dated 2/20/2011, stated,"removed 14 French foley catheter with 25 milliliter of water deflated	F0282	**F282-483.20(k)(3)(ii)** **SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** **I.** **Resident #42's order for the Foley Catheter was clarified with the physician during the survey and an order was obtained for the correct size, and the care plan was updated. In addition, the fluid requirement and bowel incontinence care plan was updated and is being followed.** **II.** **All resident's care plans are being reviewed for physician orders and care plans being followed at a rate of 10 residents per week until all resident's care plans have been reviewed. Adjustments will be made as needed during the review process. In addition, all dehydration assessments will be reviewed and care plans adjusted as appropriate for fluid needs.** **III.** **The systemic change includes that all new physician orders will be reviewed at the daily clinical meeting Monday through Friday and the care plan will be reviewed and adjusted as needed. In addition, any changes in fluid needs will be reviewed with the quarterly, and as needed, dehydration risk assessment**	04/24/2011

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	balloon. Replaced it with new 14 French foley catheter with 30 milliliter of sterile water per sterile technique." A nurse's noted dated 3/16/2011, stated, "removed old foley catheter 16 French with 30 milliliter balloon...new 16 French foley catheter placed via sterile technique with 30 milliliter balloon. A care plan for Resident #42, for bowel incontinence, with a problem and approach date of 9/24/2011, indicated the resident was to receive a minimum of 1275 milliliters of fluid per 24 hours. A vital sign report for Resident #42 plus a medication administration sheet indicated for the month of March received the following amounts of fluid: 3/22/2011 1560 milliliters 3/21/2011 780 milliliters 3/20/2011 1290 milliliters 3/19/2011 360 milliliters 3/18/2011 1200 milliliters 3/17/2011 1440 milliliters 3/16/2011 2000 milliliters 3/15/2011 820 milliliters 3/14/2011 60 milliliters 3/13/2011 540 milliliters 3/12/2011 1200 milliliters 3/11/2011 600 milliliters 3/10/2011 720 milliliters 3/9/2011 1290 milliliters		**and the care plan will be adjusted as needed.** **Education will be provided for nursing regarding updating the plan of care with new physician orders and with the quarterly and as needed dehydration risk assessment.** **IV.** **Unit Managers or designee will audit 100% of new physician orders for completion of care plan and 100% of care plans after completion of the quarterly and as needed dehydration risk assessment.** **This review will continue for a duration of 12 months.** **Any concerns will be addressed.** **The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **Completion date: 4/24/11**	

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	3/8/2011 830 milliliters 3/7/2011 880 milliliters 3/6/2011 870 milliliters 3/5/2011 900 milliliters 3/4/2011 1410 milliliters 3/3/2011 820 milliliters 3/2/2011 1200 milliliters 3/1/2011 340 milliliters 3.1-35(g)(2)			

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ALTENHEIM HEALTH & LIVING COMMUNITY LLC	3525 E HANNA AVE INDIANAPOLIS, IN46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0371 SS=F	Based on observation and interview the facility failed to ensure that food was covered and dated, raw hamburger was not thawing over boxed turkey, facial hair was covered, and failed to ensure that black mold was not growing on the walls in the dietary department. This has the potential of affecting 69 out 69 resident who reside at the facility. Findings include: During the tour of the facility's kitchen conducted with the Dietary Manager on 3/21/2011 at 10:00 a.m., the following observations were made: a) In the salad refrigerator, a gallon size zip lock bag containing what appears to be fruit salad, did not have a date on it. b) In the tray line refrigerator, there was 3 bowels of grapes, 5 bowels of apple sauce, and 5 slices of angel food cake, that was not covered or dated. c) The wall to the right of the dishwasher, behind where the dishes are loaded are loaded into the machine, there was black mold growing on the wall. d) The cooler located downstairs, had raw hamburger thawing over a box of turkey.	F0371	**F371-483.35(i)** **FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY** **I.** **The bag containing fruit salad was discarded upon discovery during the survey.** **The bowls of grapes, apple sauce and angel food cake were discarded upon discovery during the survey** **The mold on the wall to the right of the dishwasher was immediately removed and cleaned during the survey.** **The box of turkey was immediately discarded and the cooler was rearranged so that no raw meat was thawing above other food items.** **The scoop was removed from the sugar and the sugar was discarded.** **Employee #1 and #2 were immediately educated on sanitary conditions and now have any facial hair appropriately covered.** **II.** **All opened food items are now appropriately covered and dated.** **The walls in the dietary department have been cleaned and are free of black mold.** **All foods in the cooler are arranged so that no raw meat is thawing above other food items.**	04/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	e) A scoop was found in the bulk sugar container. f) Employee #1 and Employee #2 had facial hair that is not covered. During an interview with the Dietary Manager, on 3/25/2011 at 9:40 a.m., she indicated the black mold was cleaned off the wall on the evening of 3/21/2011 with bleach.. 3.1-21(i)(3)		**Scoops are not left in bulk sugar containers.** **Employees with facial hair have their hair covered appropriately.** **III.** **The systemic change includes a schedule of dietary staff with assignments for daily checklists to include the Dietary Manager to hold staff accountable for the checklist.** **Any newly hired kitchen staff will be trained on the daily checklist during orientation.** **The cleaning schedule has been reviewed and revised to include the items listed above.** **Education was provided for all dietary staff regarding the dating and covering of opened foods, cleaning schedules for the dietary walls, arrangement of foods appropriately in the cooler so that no raw meat is thawing above other food items, scoops are not left in bulk containers, and proper covering of any facial hair.** **IV.** **The Director of Dining Services or designee will complete a daily audit, 5 days a week, of proper storage and dating of opened foods, cleaning of and visual checks of the dietary department for molds, proper covering of facial hair, no scoops left in bulk containers, and appropriate arrangement**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155196	A. BUILDING 00 B. WING	03/25/2011

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			of foods in the cooler so that no raw meat is thawing above other food items. This audit will continue for 30 days, and then will be completed 2 days a week for an additional 60 days, then one day a week for an total of 12 months of monitoring. **Any concerns will be addressed.** **The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.** **Completion date: 4/24/11**	